

OTHS Athletic Training Services

CONCUSSION RETURN TO PLAY & CLEARANCE

_____ Student/Athlete Name	_____ School	_____ Sport	_____ Date of Birth
_____ Certified Athletic Trainer	_____ Email	_____ Phone	
_____ Date of Injury	_____ Date of Initial Exam	☐ YES ☐ NO Date: _____	☐ YES ☐ NO
		Parents Contacted	☐ YES ☐ NO
		Baseline Test	ImPACT Post-Test

☐ After reviewing the available medical facts, it is my opinion the above named athlete did NOT sustain a concussion on the date of injury noted and is medically released to return to play in the above sport.

☐ The above named athlete did sustain a concussion on the date of injury noted, has returned to baseline or is within the normative data standards, but has not progressed through the return to play protocol. The athlete is therefore medically released to continue to advance activities per the graduated return to play protocol (see table on page 2). The student/athlete's progress through the stages will be monitored by a licensed athletic trainer. The individual responsible for monitoring the progress of the student/athlete through the stages of the Return to Play Protocol should consult with the licensed physician when necessary and shall consult (via phone, email, or in person) with the licensed physician prior to the release of the student/athlete to return to play.

_____ Certified Athletic Trainer	☐ YES ☐ NO	_____ Post-Injury Test Clearance	_____ Physician providing clearance	_____ Date
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I certify that I have consulted with the licensed physician on this form and have received a medical release from them for the athlete named herein to return to play in the sport indicated.

Certified Athletic Trainer

Date step 5 completed asymptotically

By signing this form, the licensed physician is certifying that they are practicing within their scope of practice and the signature invokes the condition checked above.

Licensed MD/DO Physician Signature

Date of medical clearance

Date signed

Print Name

Phone